

INDIVIDUAL'S AUTHORIZATION

Purpose: This form is used to confirm the direction of an individual to authorize MDH to request, to use, or to disclose the individual's health information.

Please type or print neatly; we are not able to process incomplete or illegible forms.

☐ Check if this authorization is for psychotherapy notes.

If this authorization is for psychotherapy notes, MDH will not use it as an authorization for any other type of health information. If the individual seeks to authorize the use and disclosure of other health information as well, an additional form must be submitted.

SECTION A: Individual's Health Information authorized for Use and Disclosure.

Last Name: _____ First Name: _____ MI: _____

Street Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Phone: (home) _____ (work) _____ Date of Birth: ____/____/____

SECTION B: The Use and/or Disclosure being authorized

Provide a detailed description of the health information you are authorizing us to use and/or disclose.

The purpose of the disclosure (optional:)

Who is authorized to Disclose your health information:

MDH PROGRAM NAME(S): _____ ADDRESS: _____

TELEPHONE NUMBER: _____

Who is authorized to Receive and Use your health information:

NAME(S): _____ ADDRESS: _____

TELEPHONE NUMBER: _____

If the information which the program has includes records or information from another entity, I ____ do or ____ do not wish to have that information released under this authorization.

SECTION C: Expiration and revocation. (IF THIS SECTION IS NOT COMPLETED, MDH CANNOT ACCEPT THIS FORM.)

This authorization will expire on the earlier of the date or event listed below or one year from the date that it is signed.

Section 4-303(b) of the Health-General Article limits the period of time that an authorization is valid to no more than one year with limited exceptions.

Expiration: This authorization will expire (complete one):

- ☐ On ____/____/____
- ☐ On occurrence of the following event (which must relate to the individual or to the purpose of the use and/or disclosure being authorized):

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to MDH. In order to obtain a revocation form to revoke this authorization, I understand that I may contact _____ . I understand that revocation of this authorization will not affect any action that MDH or others named or unnamed took in reliance on this authorization before MDH received my written notice of revocation.

SECTION D: Signature.

To the Individual – Please read the following.

I authorize the use and/or disclosure of my health information as described in Section B above. I understand this authorization is voluntary.

I understand that if the persons or organizations I authorize to receive and/or use my health information are not subject to the federal or state health information privacy laws, they might further disclose the health information, and it may no longer be protected by the health information privacy laws.

I have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my intent.

Signature: _____ Date: _____

If a personal representative is making this request, please attach a copy of any document granting legal authority and complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____